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combated by a hypodermic injection of morphine and atropine, ice pack to the abdomen, perfect quiet, and elevation of the foot of the bed.

Perforation of the bowels is much more serious than the former complications and occurs in 6 per cent. of cases. Excessive tympanites predisposes the patient to this complication. It usually begins with a sudden sharp stabbing pain in the abdomen, followed by signs of collapse, rigidity of the abdominal walls, vomiting, abdominal tenderness and distention, and pinched expression. Here the nurse, alone, is much more helpless than in any other complication but some good may be done by a hypodermic of morphine and atropine, ice to the abdomen, and rapid preparation for the intervention of the surgeon.

During convalescence, responsibility is as great, if not greater, than that during the general course of the disease. As convalescence advances the visits of the physician become less and less and the responsibility of the nurse becomes greater and greater. The patient acquires a ravenous appetite and demands a greater amount of food, even making threats as to what he will do if an increased amount of diet be not forthcoming, and great vigilance on the part of the nurse is necessary.

Solid food, as has been suggested, should not be given until the temperature has been normal for ten days. In the meantime the diet can be varied with eggs in different forms, cereals, jellies, gruels, toasts, etc. Perforation of the bowel has occurred late in convalescence due to the eating of a chop. A rise in temperature may be due to a true relapse, constipation, an error in diet, or to mental excitement.

The patient should at first sit up in bed for a short time daily, then sit up in bed to eat his meals, and later to read or receive visitors. As he gains strength he may sit up in a chair for a short time, walking about the room, first aided and later unaided, and finally is allowed to assume charge of himself, the result of anxious hours on the part of the physician and nurse, for of all diseases with which we have to battle, in typhoid, "Persistency is the price of success."

A TYPHOID CASE.*

BY EMMA LONG, R.N.

Graduate of Asbury Hospital, Minneapolis, Minn.

EVERY nurse knows the usual call to work—the ringing of the telephone, packing of a suitcase, the wonder as to how you shall find things, in this state the hunting up of time tables, the rush to the depot,

* Read at the second annual meeting of the North Dakota State Nurses' Association, Fargo, April 24, 1913.

the train ride, the meeting of the patient's family, and the adapting of yourself to their conditions. My call to this particular case took me on an all night's ride across the state, and when I stepped from the train on a bright spring morning, I found I had before me a nine-mile ride to a claim shanty.

I found my patient, the man of the house, in the third week of typhoid, covered with profuse perspiration, hiccupping constantly. He had had about twelve hemorrhages and was bleeding continuously from the rectum. A baby girl of twenty months was in the first week of typhoid, the mother in the last month of pregnancy. There were no near neighbors, no telephone, the usual inconveniences due to home-staying on a claim, and we were nine miles from a doctor.

The patient's temperature was 103°. Treatment, cold sponge every three hours; adrenalin, m_x , every four hours; turpentine, m_v , given in capsule every four hours; whiskey, teaspoonful, every two hours; and a powder containing opium every four hours. Ice-bag to abdomen, and the foot of the bed elevated. The hiccupping continued for over ten days, while various remedies were tried without avail, until finally a solution of musk in alcohol was given and proved successful. Perspiration continued about three weeks. During the first ten days I was there the patient had 17 more hemorrhages, some large and containing bright red blood. As a last resort we gave hypodermically 30 minims of human blood, taken from the veins of three different men, to increase the fibrin or clotting power of the blood. We gave eight of these hypodermics eight hours apart. The blood was drawn quickly from the vein in a warm hypodermic and injected into the patient very quickly before it had time to clot, and we succeeded in checking the hemorrhages.

Only three ounces of buttermilk to the 24 hours was taken in the first few days. The patient was nervous, restless, twitching most of the time, but not delirious.

The third day we dropped the turpentine and gave strychnine, gr. $1/40$, hypodermically, every four hours, pulse being very poor, no volume, almost impossible to count.

On the sixth day, at five in the afternoon, the patient suddenly gasped, became cyanosed, and I could not feel the pulse. A hypodermic of digitalin, nitroglycerine and strychnine was given, followed by a hypodermic of brandy and a hot alcohol rub, and external heat applied. After about 20 minutes the patient rallied, but had another sinking spell at five the next morning. Then the same treatment was given and the patient rallied more quickly.

In the fourth week of disease the temperature was running from

100° to 102°, pulse very poor quality, 114 to 130, respirations from 24 to 38. At this time an abscess in the left ear broke and the discharge continued for several days. Warm irrigation of boric acid solution was used three times a day. The patient was now taking from six to eight ounces of buttermilk in the 24 hours, but continued to have a good deal of nausea with an occasional emesis.

When I arrived on the case I found the tissue over the sacrum badly necrosed, and a large bed-sore developed. If the patient were turned on either side for a few minutes he would be blue and cold, making it extremely difficult to care for a bed-sore. Treatment consisted in using a rubber ring, and warm boric acid applications were used for 48 hours to induce sloughing. Then the bed-sore was dressed several times a day by syringing first with perveide, then with a warm saline solution, and a balsam of Peru dressing was applied.

At the fourteenth day after my arrival the temperature was running 98.4° in the morning to 101°, ordinarily, in the evening, occasionally reaching 102°. Pulse still poor, volume 108 to 124, respirations 24.

The patient was taking about two pints of buttermilk and three albumins in the 24 hours; for medicine, two teaspoonfuls of whiskey every two hours, and tincture of nux vomica, ℥viii, every four hours. He was troubled greatly with rheumatic pains in the lower limbs and feet. These were kept bandaged and heat applied. Bowels were in very good condition, kept open by daily enema until they became constipated, and then cascara was given three times daily in addition to the enema.

At about the end of the sixth week, the patient was quite delirious at times, and we added gruels, junket, and egg nogs to his diet.

In the sixth week, one morning, the patient had a large, loose stool, containing some mucus. Shortly afterward he had a large emesis and complained of soreness over the entire abdomen, followed by a severe chill. His pulse suddenly failed, he was badly cyanosed. Hot-water bags were applied, camphorated oil, ℥xv, given hypodermically, followed by a hot alcohol rub. After two hours, when the pulse could be counted, it was running at 146.

The patient did not urinate for some time; he was catheterized, and only one ounce and a half of urine obtained. After four hours the patient voided four ounces of urine and had another bowel movement, composed almost entirely of mucus. Antiphlogistine and a hot-water bag were applied for the pain in the abdomen.

Through the night he slept very little, was nauseated, had a couple of emeses, pulse 136. Toward morning the abdomen was greatly distended and he was troubled with gas. A warm saline enema was given,

which helped the flatulence and relieved the pain. The next day the pain had settled over the region of the appendix. The pains and tenderness disappeared in about four days and the temperature dropped to normal.

I had to leave the patient one week after this, having been there six weeks. The temperature had been normal a week, pulse keeping 102 to 110, respiration 18. Diet, soft boiled eggs, well-cooked cereals, soft toast, in addition to liquids. The patient was in bed three weeks longer after this, and was lame from rheumatism for some time, but made a complete recovery.

I gave very little care to the baby, who ran a light attack of typhoid, and recovered nicely. The mother was confined at the home of a neighbor, and had a baby boy, the third week I was there.

One disagreeable feature of the case was the cold, rainy weather which continued most of the time, greatly aggravating my patient's rheumatism and general condition, and when it turned warm, the swarms of mosquitoes made life a burden when outside the shanty. The case, though hard, had its compensation in the experience of a most unusual typhoid case.

A MURPHY IRRIGATOR WHICH MAY BE EASILY AND ECONOMICALLY CONSTRUCTED *

BY MARY E. THORNTON, R.N.

THE irrigator is a white-enamelled solution container, fitted at its lower third outlet with a glass tube to which is attached rubber tubing with a clamp. It is possible to procure for this a new clamp which regulates the drops exactly, consisting of a screw running through three cross-bars on two side threads, procurable at any good instrument house, and an immense improvement over the hairpin arrangement many of us have had to improvise at this point. At the lower end of the rubber tubing is a double-pointed glass bulb with a pipette suspended inside; to the lower end of the bulb is attached more rubber tubing, fitted to a glass Y. One fork of this Y provides for regurgitation, by a long piece of rubber tubing with glass tube at the end. A glass feeding tube may be held over a gas flame until in such form as to hook onto the solution container. The stem of the Y has any desired length of tubing, with glass connections for observation and a vaginal tip at the end.

For keeping the solution at a uniform temperature, a glass milk

* In use in the New York Post-Graduate Medical School and Hospital.